STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155524	A. BUILDING _____ B. WING _____	C 04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GLENBURN HOME	618 W GLENBURN ROAD LINTON, IN 47441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00170534. Complaint IN0017034 - Unsubstantiated due to lack of evidence. Survey date: April 22 and 23, 2015 Facility number: 000230 Provider number: 155524 AIM number: 100275000 Census bed type: SNF: 10 SNF/NF:123 Total: 133 Census payor type: Medicare: 22 Medicaid: 80 Other: 31 Total: 133 Sample: 03 Health Center at Glenburn Home was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 - 3.1 in regards to the Investigation of Complaint IN00170534.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE